Service Canada

PROTECTED B (when completed)

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MEDICAL REPORT

TO THE PHYSICIAN

INFORMATION

Your patient is applying for a Canada Pension Plan disability benefit. To assist us in determining eligibility, please complete this form on his/her behalf. Please type or write legibly. You may substitute this report with a narrative letter or computer print-out.

The decision as to whether a person is disabled is the responsibility of Canada Pension Plan's Disability Operations Division. According to the Canada Pension Plan legislation, a disability must be a physical or mental impairment that is both **severe and prolonged. Severe** means that a person is incapable regularly of pursuing any substantially gainful occupation. **Prolonged** means that such disability is likely to be of indefinite duration or is likely to result in death. **Objective medical evidence** and other factors are considered when determining eligibility.

An applicant may be requested to undergo an independent medical examination by a physician designated by Service Canada.

ACCESS TO PERSONAL INFORMATION

Pursuant to the *Privacy Act*, upon written request, Service Canada is obligated to provide the applicant with any information or records, including medical reports, contained in their file. (Personal Information Bank ESDC PPU 146).

RETURN OF MEDICAL REPORT

Service Canada will assist with the cost of completing the Medical Report by paying up to $85.00 directly to you. To ensure payment, please include an original invoice with your report.

Your invoice must include our client's name, address and identification number. Depending on your practice or business, your invoice must include one of the following for Canada Revenue Agency (CRA) purposes:

- your Business Number (BN); or
- your Goods and Services Tax (GST) / Harmonized Sales Tax (HST) number; or
- your Social Insurance Number (SIN).

Without this information, you and/or the Canada Pension Plan may be subject to a fine as noted in the *Income Tax Act* paragraph 221(1).

If you have any questions, please contact Service Canada at 1-800-277-9914, TTY users 1-800-255-4786.

A DELAY IN THE COMPLETION OF THIS MEDICAL REPORT MAY AFFECT YOUR PATIENT'S ENTITLEMENT TO BENEFITS.

IT IS AN OFFENCE TO MAKE A FALSE OR MISLEADING STATEMENT IN AN APPLICATION FOR BENEFITS.

MEDICAL REPORT

SECTION A - To be completed by Applicant

Given Name and Initial	Family Name

Home Address (No., Street, Apt. No., R.R.)

City, Town or Village	Province or Territory	Postal Code

Telephone number	Date of Birth - (Year Month Day)	**Social Insurance Number**

SECTION B - To be completed by Physician

Please provide factual objective opinions

1. Height Weight	2a. How long have you known the patient?	b. When did you start treating the patient for the main medical condition? Year Month	c. Date of last visit Year Month Day

3. Diagnosis(es):

4. Relevant/significant medical history relating to the main medical condition:

Please write legibly

Service Canada delivers Employment and Social Development Canada programs and services for the Government of Canada.

Social Insurance Number

5. Over the past two years, has the patient been admitted to a hospital/institution?

◯ Yes **If yes,** please list:

◯ No

Name of the Hospital(s)/Institution(s)

The date(s) of admission Year Month Day	The reason(s) for admission

6A. Is there supporting evidence for the main medical condition? Please attach supporting documentation.

Laboratory Reports	◯ Yes	◯ No
X-ray reports	◯ Yes	◯ No
Consultants' opinions	◯ Yes	◯ No
Other	◯ Yes	◯ No
Documentation to be returned	◯ Yes	◯ No

6B. Please describe relevant physical findings and functional limitations.

Please write legibly

7. Are further consultations or medical investigations planned relating to the main medical condition?

◯ Yes **If yes,** please specify:

◯ No

8. Is the patient currently on medication(s) as a result of the main medical condition?

◯ Yes **If yes,** please indicate dosage and frequency.

◯ No

9. Treatment: List type and response.

Please write legibly

Social Insurance Number

FOR OFFICE USE ONLY		
☐ A.C.	Initials	Year Month Day

10. Prognosis of the main medical condition of this patient:

11. Additional Information:

SIGNATURE (Please print or use a stamp)

Physician's Full Name

Address

Postal Code

☐ Family Physician

☐ Specialty _____

Signature X	Year Month Day	Telephone No.

Please write legibly

Service Canada

Service Canada Offices
Disability

Mail your forms to:
The nearest Service Canada office listed below.
From outside of Canada: The Service Canada office in the **province where you last resided**.

Need help completing the forms?
Canada or the United States: **1-800-277-9914**
All other countries: **613-990-2244** (we accept collect calls)
TTY: **1-800-255-4786**
Important: Please have your social insurance number ready when you call.

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